Dr. Lauretta Justin, O.D.
Millennium Eye Center

Patient's Name: _____ DOB: _____ Date: _____

PUPIL DILATION & LIFETIME INSURANCE ASSIGNMENT CONSENT

*PLEASE **PUT A CHECK MARK** NEXT TO EACH APPLICABLE STATEMENT AND SIGN BELOW TO GIVE US CONSENT TO SERVE YOU.*

- ☐ I have read the pupil dilation information form, and **I consent** to pupil dilation.
- ☐ I have read the pupil dilation information form and **I DO NOT consent** to pupil dilation at my own risks. The doctor will not be held liable for any undetected medical and/or other eye conditions that may affect my vision as a result of my decision.
- ☐ I certify I have read all information outlined in **the lifetime insurance assignment** and that I am the patient and/or authorized as the patient's guardian or representative and have the authority to accept and execute the above terms and conditions.

_____ _____

Patient/Guarantor Name (print): Signature (*For under age 18, a parent, guardian or representative must sign)*

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Millennium Eye Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Millennium Eye Center, Inc.'s Notice of Privacy Practice and agree to continue my care with Millennium Eye Center, Inc. under said terms.
- ☐ I was given to opportunity to read Millennium Eye Center, Inc.'s Notice of Privacy Practices and declined but wish to continue my care with Millennium Eye Center, Inc. under the terms of Millennium Eye Center, Inc.'s privacy policies.
- ☐ I have read or had explained to me Millennium Eye Center, Inc.'s Notice of Privacy Practice and do not wish to continue my care with Millennium Eye Center, Inc. under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as _____

I have read and understand this form. I am signing it voluntarily.

_____ _____

Patient/Guarantor Name (print): Signature (*For under age 18, a parent, guardian or representative must sign)*

6601 Old Winter Garden Rd. Suite 104, Orlando, FL 32835 ● Phone: 407-292-9812 Fax: 407-292-9813
Email. info@drlaurettajustin.com Website: DrLaurettaJustin.com

Dr. Lauretta Justin, O.D.
Millennium Eye Center

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize Millennium Eye Center, Inc. to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) to the following:

Name_____ Relationship: _____
Address: _____
Phone: _____ Fax: _____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient

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